AMENDED IN SENATE MARCH 14, 2017

SENATE BILL No. 17

Introduced by Senator Hernandez
(Principal coauthor: Assembly Member Chiu)

December 5, 2016

An act *to amend Section 1385.045 of, to add Section 1367.245 to, and to add and repeal Chapter 9 (commencing with Section 127675) of Part 2 of Division 107 of, the Health and Safety Code, and to amend Section 10181.45 of, and to add Section 10123.204 to, the Insurance Code,* relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 17, as amended, Hernandez. ~~Prescription drugs: pricing: notification.~~ *Health care: prescription drug costs.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC) and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance (DOI). Existing law requires health care service plans and health insurers to file specified rate information with DMHC or DOI, as applicable, for health care service plan contracts or health insurance policies in the individual or small group markets and for health care service plan contracts and health insurance policies in the large group market.

This bill would require health care service plans or health insurers that file the above-described rate information to report to DMHC or DOI, on a date no later than the reporting of the rate information, specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs,

dispensed as provided. DMHC and DOI would be required to compile the reported information into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums and publish the reports on their Internet Web sites by January 1 of each year. Except for the report, DMHC and DOI would be required to keep confidential all information provided pursuant to these provisions. The bill would also require health care service plans or health insurers that file the above-described rate information to disclose to DMHC and DOI with the rate information specified information regarding the relation of prescription drug costs to plan or insurer spending and premium charges. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would require a manufacturer of a prescription drug that is purchased or reimbursed by specified purchasers, including state agencies, health care service plans, health insurers, and pharmacy benefit managers, to notify the purchaser if the wholesale acquisition cost of a prescription drug exceeds a specified threshold. The bill would require the manufacturer to notify the Office of Statewide Health Planning and Development (OSHPD) of specified information relating to that increase in wholesale acquisition cost at the time that the increase takes effect. The bill would require the manufacturer to notify OSHPD of specified information relating to the wholesale acquisition cost of a new prescription drug if the cost exceeds a specified threshold. The bill would require OSHPD to enforce these provisions and would subject a manufacturer to liability for a civil penalty if the information described above is not reported. The bill would authorize OSHPD to adopt regulations or issue guidance for the implementation of these provisions.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law establishes various programs to assist individuals with the purchase of prescription drugs at affordable prices, including, among other programs, the California Rx Prescription Drug Web Site Program and the Golden Bear State Pharmacy Assistance Program.~~

~~This bill would state the intent of the Legislature to enact legislation requiring public and private purchasers of health care and health care coverage be given advance notice of price increases for the costs of prescription drugs in order to further the ability to predict and manage these costs and the public be given information about the justification, if any, for the prices of newly emerging medications and price increases for existing prescription drugs. This bill would include the findings and declarations of the Legislature in support of its intent.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.245 is added to the Health and Safety Code, to read:

1367.245. (a) (1) A health care service plan that reports rate information pursuant to Section 1385.03 or 1385.045 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health care service plans.

(c) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2019, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 1385.045.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and that information shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

SEC. 2. Section 1385.045 of the Health and Safety Code is amended to read:

1385.045. (a) For large group health care service plan contracts, each health plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within three months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting

shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost ~~sharing.~~ *sharing, including cost sharing for prescription drugs.*

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category,

including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as

any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in total spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, ~~2016,~~ *2018,* and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 3. Chapter 9 (commencing with Section 127675) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 9. PRESCRIPTION DRUG PRICING FOR PURCHASERS

127675. (a) This chapter shall apply to a manufacturer of a prescription drug that is purchased or reimbursed by any of the following:

(1) A state purchaser in California, including, but not limited to, the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, and the Department of Corrections and Rehabilitation, or an entity acting on behalf of a state purchaser.

(2) A licensed health care service plan.

(3) A health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(4) A pharmacy benefit manager as defined in subdivision (j) of Section 4430 of the Business and Professions Code.

(b) For the purposes of this chapter, the term "office" shall mean the Office of Statewide Health Planning and Development.

127677. (a) A manufacturer of a prescription drug shall notify each purchaser described in Section 127675 that it is increasing the wholesale acquisition cost of a prescription drug if any of the following circumstances apply:

(1) The wholesale acquisition cost for the prescription drug is under the threshold set for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)) and if the cumulative increase is more than 25 percent over the three calendar years prior to the current year.

(2) The wholesale acquisition cost for the prescription drug is over the threshold set for a specialty drug under the Medicare

Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)), and if the cumulative increase is more than 10 percent over the three calendar years prior to the current year.

(b) The notice required by subdivision (a) shall be provided in writing at least 90 days prior to the planned effective date of the increase.

(c) The notice required by subdivision (a) shall include a statement of any changes or improvements to the clinical efficacy of the drug that explain the increase in wholesale acquisition cost. The manufacturer shall state if there are no changes or improvements made to the clinical efficacy of the drug subject to the notice.

(d) The notice required by subdivision (a) shall not be required for a prescription drug that is not already purchased or reimbursed by a purchaser described in subdivision (a), except for prescription drugs described in Section 127681.

(e) If a pharmacy benefit manager receives a notice of an increase in wholesale acquisition cost consistent with subdivision (a), it shall notify its large contracting public and private purchasers of the increase. For the purposes of this section, a "large purchaser" means a purchaser that provides coverage to more than 500 covered lives.

127679. (a) At the time that the increase in wholesale acquisition cost described in subdivision (a) of Section 127677 takes effect, a manufacturer shall report all of the following information to the office:

(1) A description of the specific financial and nonfinancial factors used to make the decision to increase the wholesale acquisition cost of the drug and the amount of the increase, including, but not limited to, an explanation of how these factors justify the increase in the wholesale acquisition cost of the drug.

(2) The previous year's marketing budget for the drug, including the budget for patient assistance programs specific to the drug.

(3) A schedule of wholesale acquisition cost increases for the drug for the previous five years if the drug was manufactured by the company.

(4) If the drug was acquired by the manufacturer within the previous five years, all of the following information:

(A) The wholesale acquisition cost of the drug at the time of acquisition and in the calendar year prior to acquisition.

(B) The name of the company from which the drug was acquired, the date acquired, and the purchase price.

(C) The year the drug was introduced to market and the wholesale acquisition cost of the drug at the time of introduction.

(5) The patent expiration date of the drug if it is under patent.

(6) If the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug, as defined in subparagraph (A) of paragraph (7) of subdivision (k) of Section 1396r–8 of Title 42 of the United States Code.

(7) Documentation of increased clinical efficacy of the drug, if any. The manufacturer shall state if the drug subject to the notice does not exceed the clinical efficacy of existing treatments.

(8) Volume of sales of the drug in the United States for the previous year.

(b) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a quarterly basis. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

127681. (a) A manufacturer of a prescription drug shall notify the office in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)). The notice shall be provided in writing within three days of commercial availability. A manufacturer may make this notification pending approval by the federal Food and Drug Administration, if commercial availability is expected within three days of approval.

(b) Within 30 days of notification pursuant to this section, a manufacturer shall report all of the following information to the office:

(1) A description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally.

(2) The estimated volume of patients that may be prescribed the drug.

(3) Any documentation showing increased efficacy of the drug compared to existing treatments. The manufacturer shall state if there are no changes or improvements made to the clinical efficacy of the drug subject to the notice.

(4) If the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval.

(5) The expected marketing budget for the drug, including the budget for patient assistance programs.

(6) The date and price of acquisition if the drug was not developed by the manufacturer.

(c) The office shall publish the information provided to it pursuant to this section on its Internet Web site on no less than a monthly basis. The information shall be published in a manner that identifies the information that is disclosed on a per-drug basis and shall not be aggregated in a manner that would not allow identification of the drug.

127683. (a) A manufacturer of a prescription drug subject to the requirements of this chapter shall comply with this chapter. The office shall be responsible for the enforcement of these provisions.

(b) (1) A manufacturer of a prescription drug subject to this chapter that does not report the information required pursuant to this chapter to state purchasers, health care service plans, health insurers, or pharmacy benefit managers is liable for a civil penalty of one thousand dollars ($1,000) per day for every day after the applicable notification period that the required information is not reported.

(2) A civil penalty shall be assessed and recovered in a civil action brought by the office in the name of the people of the State of California. Assessment of a civil penalty may, at the request of any manufacturer of a prescription drug subject to this chapter, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(c) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

127685. (a) The office may adopt regulations or issue guidance for the implementation of this chapter.

(b) The office may consult with the Department of Managed Health Care, the Department of Insurance, the California State

Board of Pharmacy, and any state purchaser of prescription drugs, or an entity acting on behalf of a state purchaser, in issuing guidance or adopting necessary regulations pursuant to subdivision (a), in posting information on its Internet Web site pursuant to this chapter, and in taking any other action for the purpose of implementing this chapter.

SEC. 4. Section 10123.204 is added to the Insurance Code, to read:

10123.204. (a) (1) A health insurer that reports rate information pursuant to Section 10181.3 or 10181.45 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health care service plans.

(c) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2018, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 10181.45.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and that information shall be exempt from disclosure under the California

Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

SEC. 5. Section 10181.45 of the Insurance Code is amended to read:

10181.45. (a) For large group health insurance policies, each health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within three months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost ~~sharing.~~ *sharing, including cost sharing for prescription drugs.*

(I) Covered benefits in addition to basic health care services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the health insurer's insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same or similar to those used by other insurers.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health

insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other insurers.

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in total spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 6. The Legislature finds and declares that Sections 1 and 4 of this act, which add Section 1367.245 to the Health and Safety Code and Section 10123.204 to the Insurance Code, respectively, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect proprietary, confidential information regarding health care service plan and health insurer prescription drug utilization and spending information that is specific to the plan or insurer and to protect the integrity of the competitive market, it is necessary that this act limit the public's right of access to that information.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. The Legislature finds and declares all of the following:~~

~~(a) Health care spending in the United States is twice the level of health care spending in other developed countries while life expectancy is often less.~~

~~(b) Health care spending in the United States has climbed from about $1,000 per person to almost $9,000 per person while the rate of growth for health care spending in other developed countries has been much more modest.~~

~~(c) High health care spending is paid for by individual consumers, employers, taxpayers, and other purchasers of health care services and coverage. While existing state and federal law limits the profit and overhead of health plans and health insurers, there are no similar limits on the profits and overhead of pharmaceutical manufacturers.~~

~~(d) The United States has experienced significant growth in spending on prescription drugs so that total prescription drug costs in the United States exceeded $450 billion, or 16.7 percent of personal health care spending in 2015, up from $367 billion or 15.4 percent of personal health care spending in 2012. For persons under 65 years of age, the cost of outpatient prescription drug spending amounts to 19 percent of the premium dollar, and that 19 percent spent on outpatient drugs does not account for drugs administered by a health professional, such as chemotherapy or~~

~~drugs administered in a hospital or other health facility, which further compounds spending on prescription drugs.~~

~~(e) Specialty drug spending rose 30.9 percent between 2013 and 2014 while specialty drugs accounted for 1 percent of prescriptions in 2013. These drugs accounted for 25 percent of prescription drugs spending in 2013. Cancer drug prices doubled within the last decade, from an average of $5,000 per month to an average of $10,000 per month.~~

~~(f) Approximately 75 percent of the increase in Medicaid spending on prescription drugs between 2013 and 2104 was due to increases in price. Many prescription drugs had increases in unit prices, including Ativan, which increased 1,264 percent between 2014 and 2015, and five other drugs that had unit cost increases of more than 300 percent between 2014 and 2015. From the fourth quarter of 2013 to the second quarter of 2016, Epi-Pen prices increased 15 percent every other quarter so that the price had increased 548 percent since 2007. Of the 20 drugs with the highest per unit cost increases in Medicaid, nine were generic drugs and those products had increases in price ranging from 140 percent to nearly 500 percent between 2014 and 2015.~~

~~(g) The State of California spent more than $4 billion in taxpayer dollars on prescription drugs in the 2014–15 fiscal year and this amount did not include prescription drug spending for the almost ten million people enrolled in Medi-Cal managed care.~~

~~(h) The 2016 Kaiser Health Foundation tracking poll found that 77 percent of Americans say prescription drug costs are unreasonable, 86 percent of Americans favor requiring drug companies to release information to the public on how drug prices are set, and 78 percent of Americans support limiting the amount drug companies can charge for high cost drugs for illnesses like cancer or hepatitis.~~

~~(i) Despite intense public scrutiny and broad consumer concern about escalating prescription drug prices, prescription drug prices climbed by 7 percent in September 2016, while overall health care costs climbed only 2.1 percent with nondrug costs climbing even more modestly.~~

~~SEC. 2. It is the intent of the Legislature to enact legislation requiring public and private purchasers of health care and health care coverage be given advance notice of price increases for the costs of prescription drugs in order to further the ability to predict~~

~~and manage these costs and the public be given information about the justification, if any, for the prices of newly emerging medications and price increases for existing prescription drugs.~~

O